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ANNALS
OF
SURGERY

A MONTHLY REVIEW OF SURGICAL SCIENCE AND PRACTICE

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UNIVERSITY OF PENNSYLVANIA PRESS,
PHILADELPHIA, PA.

Great Britain: Cassell and Company, London.

\$5.00 a Year in Advance.
Single Number, 75c.

One Quotation a Year in Advance.
Single Copies, 75c.

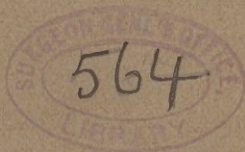
NOVEMBER, 1896

EXTIRPATION OF THE RECTUM PER VAGINAM, WITH
UTILIZATION OF THE VAGINA TO REPLACE
THE LOST RECTAL TISSUE.

By HENRY T. BYFORD, M.D.,

OF CHICAGO.

presented by the author



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EXCISION of the rectum by means of perineal section is practical only for the lower four inches, while excisions by the sacral methods are exceedingly bloody and involve great mutilation. Hence I felt justified in a recent case in attempting the operation by what to me was a new route,—viz., vaginal section. The disease extended somewhat higher than I supposed, and the case proved an exceedingly difficult one upon which to try a new method. Yet the mechanical difficulties were so perfectly overcome that the operation, although unsuccessful as far as the saving of life was concerned, seems to me worthy of record as a step in the right direction.

Mrs. Q. consulted me for a cylinder-celled carcinoma, somewhat larger than a large goose-egg, developed in the posterior and right lateral wall of the rectum. About one-third of it projected into the rectum. Its lower border was three inches from the margin of the anal skin, its upper border about two and a half inches higher up. As the mass was not fixed to the surrounding parts, although it extended above the bottom of the cul-de-sac of Douglas, I felt that it could be best reached by a vaginal section, and that the opening which would probably be made into the peritoneal cavity could be much more easily managed than it could from a sacral incision.

The patient was a nullipara, yet it was possible to sufficiently distend the vagina by retractors, aided by a slight median laceration that occurred during the operation, to work advantageously. I first made a transverse vaginal incision about half an inch below and



behind the cervix, and with the fingers separated the vagina from the connective tissue about the incision. I then separated the tumor and rectum from their connections as far up as and above the pelvic brim. Large gauze sponges were pushed up alongside the rectum to prevent hæmorrhage. The rectum below the tumor was now separated from its attachments and the tumor pulled down to the vulva. This manœuvre tore the cul-de-sac wide open and brought down into the vagina two inches of rectum, whose anterior surface was covered with peritoneum. That portion of the rectum containing the tumor was then excised between large hæmostatic forceps above and below acting as clamps. As the upper cut end of the rectum could not be brought down to meet the lower portion, it was sutured into the vaginal wound so as to close the peritoneal cavity and turning the rectum into the vagina.

As soon as the peritoneal cavity was closed, and before suturing the rest of the vaginal wound about the upper end of the rectum, I sewed around the lower end of the rectum (which was about two inches long) with catgut in such a way as to check the bleeding from the cut edges, but not to obliterate its lumen. The bleeding connective-tissue space was then packed anew with gauze strips whose ends were brought through the anus. The vaginal incision was completely closed around the rectum; thus the vagina and upper rectum were separated from the connective tissue and anus. It was my intention at another sitting to attach the lower portion of the rectum to an artificial opening in the posterior vaginal wall and close up the vaginal entrance. Thus the vagina would be made to replace the lost portion of the rectum, and the evacuations would occur naturally through the anus. In another case in which I had removed a portion of the recto-vaginal septum for carcinoma of the rectum, I closed the vaginal outlet and thus utilized the vagina. The patient lived for about a year, and passed the fæces naturally *per rectum*.

Having completed the operation and overcome the difficulties, I can look back and see how my technique might have been improved. The transverse incision might have been enlarged by a median line incision extending from its centre down, as in the letter T. If necessary to procure space, the median incision could extend through the perineal body, and thus expose the rectum more perfectly as well as relax the vaginal outlet.

A large amount of packing should be used. The separation

of the upper rectum leaves an immense oozing space bounded above by partly loosened peritoneal membrane. This space should be filled tight with gauze before the suturing commences. The separation of the upper rectum posteriorly might have been sufficient without such extensive lateral tearing, and thus much oozing would have been prevented.

L. L. McArthur in 1890 sutured the rectum into the vagina by means of the sacral incision.¹ The patient always had sufficient warning of an evacuation to get to the closet, and had some control.

Dr. Joseph Price recently removed the uterus and a portion of the rectum by abdominal section, and sutured the rectum to the vagina, thus producing a "recto-vaginal anastomosis."²

Among the advantages of the vaginal method might be mentioned the following:

(1) The vagina can be made to take the place of the extirpated portion of the rectum.

(2) The excision can be done as high up as by the sacral method and with less traumatism, and in case the peritoneal cavity is opened with less danger.

(3) An intraperitoneal exploration of the tissues about the rectum can be made before disturbing the rectum.

(4) If the operation has to be abandoned after the incisions are made, the wound is less formidable and in a better place.

(5) The patient is more comfortable after the operation than after the sacral methods.

Price's abdominal method possesses nearly all of these advantages, but is more dangerous, necessitates a removal of the uterus, and cannot be adapted to cases extending low down in the rectum.

McArthur's method is more dangerous in cases high enough up to involve an opening into the peritoneal cavity, and in all cases involves more traumatism.

¹ American Journal of Obstetrics, Vol. xxiv, p. 567.

² Medical and Surgical Reporter, May 16, 1896.

